STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A015	A. BUILDING _____ B. WING _____	C 08/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEPTIONAL CARE FOR CHILDREN	11 INDEPENDENCE WAY NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 4, 2010 through August 9, 2010. The deficiencies contained in this report are based on interviews, record reviews and review of other documentation as indicated. The facility census the first day of the survey was 21 (twenty one). The survey sample totaled 10 (ten) residents, which included 9 (nine) active records and 1 (one) closed record.	F 000		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, employee records and staff interview, it was determined that the facility failed to ensure that four (4) of six (6) sampled contractors received abuse prohibition training on an annual basis (E3, E4, E5 and E6). Findings include: 1. Review of employee files indicated that E3 (Occupational Therapist) was hired on 2/23/2009. There was no evidence that E3 received annual abuse prohibition training since 2/27/2009. 2. Review of employee files indicated that E4 (Speech Therapist) was hired on 1/18/1999. There was no evidence that E4 received annual abuse prohibition training since 8/1/2004. 3. Review of employee files indicated that E5	F 226	F226 1. Prohibition training will be provided to all contracted therapy employees. 2. All contracted employees will be required to attend a mandatory inservice training for Prohibition prior to initiation of services and annually thereafter. 3. The Director of Human Resources will ensure that all contracted employees attend a mandatory Prohibition Training prior to commencement of services. 30 days prior to renewal of contracted services, annual training will be provided. New or additional contracted employees will receive training prior to initial services being provided by that individual and 30 days prior to renewal of contract. 4. NHA will review Employee List of Contracted Services prior to commencement of contract to ensure training was completed. NHA will not review contract until all employees have completed annual training.	9/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: C Moore NHH | TITLE: Administrator | (X6) DATE: 8/25/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 1 (Speech Therapist) was hired on 8/18/2005. There was no evidence that E5 received annual abuse prohibition training since 10/1/2005. 4. Review of employee files indicated that E6 (Occupational Therapist Supervisor) was hired on 4/24/1995. There was no evidence that E6 received annual abuse prohibition training since 5/1/2004. Review of the facility Policy and Procedure entitled " Residents ' Rights/Residents ' Abuse Prohibition " under Training indicated that " All employees must undergo mandatory new employee orientation and annual updates to review the definitions of abuse, neglect and misappropriation of resident property. " Review of the facility Agreement for Therapy Services concerning personnel qualifications failed to address annual prohibition training. During an interview on 8/4/2010, E1 (Administrator) stated that abuse prohibition training was an annual requirement.	F 226		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 2 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have accurate Minimum Data Set (MDS) assessments to reflect current residents' status for 6 (R1, R2, R4, R5, R7 and R8) out of 10 sampled residents. Findings include: 1. R8, a newborn infant, had an admission MDS assessment, dated 7/31/10, that was not accurate. R8 received all nutrition by a nasogastric tube (a tube that is inserted through the nose and into the stomach). However, the MDS was not checked for the feeding tube nor for the amount of total calories and fluid intake daily via the tube. Additionally, R8 was admitted to hospice services on 7/27/10 but the MDS was not checked for hospice care. Findings were confirmed with E2 (Director of Nursing, DON) on 8/9/10.	F 278	F278 1. The MDSs for Residents # 1, # 2, # 4, # 5, # 7, and # 8 will be corrected with the next required MDS assessment per the RAI guidelines. MDS errors related to Hospice services will be modified and resubmitted per RAI guidelines. 2. All current resident MDSs will be reviewed for accuracy related to ARD date, NG tube utilization, fluid volume intake, Hospice Services, ostomy utilization, height, and balance. Corrections will be made according to the RAI guidelines or with the next quarterly assessment. 3. Each MDS will be reviewed by the DON prior to submission to ensure accuracy. 4. The DON will track and trend all MDS audit results in the areas noted above for 90 days and report findings to QA Committee for further recommendations.	9/27/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 3 2. R5 received nutrition by gastrostomy tube (a feeding tube in the stomach). R5 had MDS assessments that were not accurate. The admission MDS, dated 2/12/10 and the quarterly MDS, dated 5/10/10 both incorrectly had "none" as the average fluid intake daily via the tube. Findings were confirmed with E2(DON) on 8/9/10. 3. R4 had an MDS assessment that was not accurate. The quarterly MDS, dated 6/6/10, was reviewed and revealed an incorrect height of 52 inches. The 12/8/09 annual MDS recorded a height of 64 inches. On 8/9/10 during an interview with E2 (DON), she stated that R4's 7/10 height measured 158.48 cm (62.4 inches). Findings were confirmed with E2 on 8/9/10. 4. R7 was a 5 month old infant upon admission to the facility on 10/1/09. R7 had MDS assessments that were not accurate. The following MDS assessments were reviewed and revealed: - The admission MDS, dated 10/7/09, incorrectly coded that R7 maintained standing and sitting balance as required in the test for balance. Review of the Physical Therapy (PT) Evaluation, dated 10/5/09, documented that R7's gross motor development level was 0 to 2 months; - The quarterly MDS, dated 6/27/10, incorrectly listed (H3 section i) "ostomy present". However, record review revealed that R7 had a gastrostomy tube only which should not have been included as an ostomy. Findings were confirmed with E2 (DON) on 8/9/10. 5. R2, a 5 year old child, had MDS assessments that were not accurate. The following MDS	F 278		

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F 278	Continued From page 4 assessments were reviewed and revealed: - The annual MDS, dated 8/7/09, revealed an incorrect height of 81 inches; - On 3/9/10, R2 was admitted to the facility from the hospital. The admission MDS incorrectly had the assessment reference date as 3/9/10 The MDS assessment was signed that it was completed on 3/17/10; - The quarterly MDS, dated 6/8/10, incorrectly listed (H3 section i) "ostomy present". However, record review revealed that R2 had a gastrostomy tube only, which should not have been included as an ostomy. Additionally, this MDS failed to include hospice care which R2 had been receiving since 3/10. Findings were confirmed with E2 (DON) on 8/6/10. 6. Review of a quarterly MDS assessment, dated 7/3/10, for R1, incorrectly listed (H3 section i) "ostomy present". Record review indicated that R1 had a gastrostomy tube only, which should not have been included as an ostomy. Findings were confirmed with E2 (DON) on 8/6/10.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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F 279	Continued From page 5 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based upon interview and record review, it was determined that the facility failed to develop care plans based upon the comprehensive assessment for 2 (R2 and R8) out of 10 sampled residents. Findings include: 1. R2, a 5 year old resident with diagnoses of cerebral palsy, epilepsy, and respiratory distress syndrome, was readmitted to the facility on 3/9/10 after being hospitalized with pneumonia. R2 was admitted to hospice services on 3/29/10. Review of the care plans developed on 4/6/10 and revised on 6/10/10 revealed that the facility failed to develop a hospice care plan for R2. Findings were confirmed by E2 (Director of Nursing, DON) on 8/9/10. 2. R8, a newborn infant with a diagnosis of an occipital encephalocele, (A cerebral tissue herniation occurring through a congenital defect in the skull. The quantity and location of protruding neural tissue determines the type and degree of neurologic deficit) was admitted to the facility on 7/22/10. R8 was admitted to hospice services on 7/26/10.	F 279	F279 1. Residents # 2s Care Plan has been updated to reflect Hospice Services. Resident # 8 has been discharged. 2. All Care Plans for residents currently utilizing Hospice Services or Palliative Care will be reviewed to insure accuracy. 3. All residents, upon admission, or change in condition where Hospice or Palliative Care Services are initiated, will have a Care Plan reflective of services utilized. 4. The Director of Social Service will review and audit the Care Plans for residents utilizing Hospice or Palliative Care Services to ensure inclusion every 30 days. Results of the audit will be provided to QA for further recommendation.	9/27/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 6 Review of the care plans developed on 7/30/10 revealed that the facility failed to develop a hospice care plan for R8. Findings were confirmed by E2 (DON)on 8/9/10.	F 279		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Exceptional Care for Children

DATE SURVEY COMPLETED: August 9, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from August 4, 2010 through August 9, 2010. The deficiencies contained in this report are based on interviews, record reviews and review of other documentation as indicated. The facility census the first day of the survey was 21 (twenty one). The survey sample totaled 10 (ten) residents, which included 9 (nine) active records and 1(one) closed record.	F226 1. Prohibition training will be provided to all contracted therapy employees. 2. All contracted employees will be required to attend a mandatory inservice training for Prohibition prior to initiation of services and annually thereafter. 3. The Director of Human Resources will ensure that all contracted employees attend a mandatory Prohibition Training prior to commencement of services. 30 days prior to renewal of contracted services, annual training will be provided. New or additional contracted employees will receive training prior to initial services being provided by that individual and 30 days prior to renewal of contract. 4. NHA will review Employee List of Contracted Services prior to commencement of contract to ensure training was completed. NHA will not review contract until all employees have completed annual training. 9/27/10
3201	**Regulations for Skilled and Intermediate Care**	
3201.1.0	**Scope**	
3201.1.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as referenced by:** Cross refer to CMS 2567-L survey report completed 8/9/10, F226, F278 and F279.	F278 1. The MDSs for Residents # 1, # 2, # 4, # 5, # 7, and # 8 will be corrected with the next required MDS assessment per the RAI guidelines. MDS errors related to Hospice services will be modified and resubmitted per RAI guidelines. 2. All current resident MDSs will be reviewed for accuracy related to ARD date, NG tube utilization, fluid volume intake, Hospice Services, ostomy utilization, height, and balance. Corrections will be made according to the RAI guidelines or with the next quarterly assessment. 3. Each MDS will be reviewed by the DON prior to submission to ensure accuracy. 4. The DON will track and trend all MDS audit results in the areas noted above for 90 days and report findings to QA Committee for further recommendations. 9/27/10 F279 1. Residents # 2s Care Plan has been updated to reflect Hospice Services. Resident # 8 has been discharged. 2. All Care Plans for residents currently utilizing Hospice Services or Palliative Care will be reviewed to insure accuracy. 3. All residents, upon admission, or change in condition where Hospice or Palliative Care Services are initiated, will have a Care Plan reflective of services utilized. 4. The Director of Social Service will review and audit the Care Plans for residents utilizing Hospice or Palliative Care Services to ensure inclusion every 30 days. Results of the audit will be provided to QA for further recommendation. 9/27/10

Provider's Signature C. Moore NHA Title Administrator Date 8/25/10